



Florida Medical Manufacturers' Consortium, Inc.

□ *Linking technologies that save lives* □

FLORIDA MEDICAL MANUFACTURERS' CONSORTIUM

MEMBERSHIP APPLICATION

Primary Contact Name _____ Email _____

Additional Contact Name _____ Email _____

Company _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Fax (____) _____ Website _____

Company description _____

FMMC MEMBERSHIP INFORMATION

- **Regular Member:** \$350.00, a company that derives at least 50% of its sales from medical products; an organization that is a governmental agency, university or non-profit.
- **Associate Member:** \$500.00, for all other companies having an interest in Florida's medical manufacturing industry. *To be considered, the individual requesting membership must be sponsored by an established FMMC member.*

Name of nominating FMMC member _____

Visit www.FlaMedMfg.org/bylaws.htm to review FMMC By-Laws and the rights, privileges and responsibilities of membership.

Payment Information (please check one)

_____ **Check Enclosed.** Please make checks payable to the FMMC. Check # _____

Credit Card Payment _____ Master Card _____ VISA _____ AMEX

Credit Card Number _____ Exp Date _____ Security Code* _____

*This is the 3 digit number that appears on the reverse of your credit card. For AMEX cards only, this is the 4 digit number on the front of your card.

Cardholder Name _____ Signature _____

Billing Address and Phone Number if different from registration _____

Please note that all memberships are subject to approval by the Board of Directors. Full payment for annual dues must accompany this application.

Please make checks payable to:
Florida Medical Manufacturers' Consortium
P.O. Box 7683
Tallahassee, FL 32314-7683

Phone 850.270.3158 Fax (850.201.6966 www.FlaMedMfg.org